Patient Safety Innovation Award - 2019 Nomination Form

For questions about submitting a nomination for the award, contact Casey Hutchens chutchens@IHAconnect.org.

Overview

The Indiana Patient Safety Center (IPSC) has established the annual Patient Safety Awards to recognize individuals, groups and organizations who have helped bring Indiana closer to the goal of zero patient harms. These awards will honor commitment and enthusiasm for improving patient safety in hospitals and communities across the state.

The Patient Safety Innovation Award recognizes an individual, group or program that has developed innovative ways to improve, encourage or enhance patient safety within their hospital, health system, regional patient safety coalition or professional organization. This could mean developing a new program, process or campaign or leveraging an existing process or tool in a new way. Winners will demonstrate creativity and forward thinking.

Submit your nomination by filling out the following form and submitting a brief narrative. Supporting documents may be attached to enhance your nomination.

The nomination period is open from Feb. 25 to April 8. Nominations will be carefully considered by a committee of health care professionals and patient safety advocates, with winners announced at the Patient Safety Summit June 4.

2018 Winner: The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital

The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital received the 2018 Patient Safety Innovation Award for their outstanding work improving continuity of care medication safety by targeting high-risk patients to receive a TOC pharmacist evaluation of patient's medication therapy. Through this unique approach to patient care, the team at Franciscan Health Hammond Hospital removed patient care silos by bridging the gaps in care in all aspects of a patient's healthcare experience. The Comprehensive Transitions of Care (TOC) Pharmacy Program was created to bridge gaps in transition of care from the hospital to home and, ultimately, decrease hospital readmissions of high-risk patients.

2019 Nomination Form

NOMINATOR INFORMATION

Name *

Jim Fuller

Job Title *

President

Hospital/Organization *

Indianapolis Coalition for Patient Safety, Inc.

Address *

410 W 10th Street, Suite 3107, Indianapolis, IN 46202

Email *

jfuller@indypatientsafety.org

Phone Number *

317-223-3090

NOMINEE INFORMATION

I am nominating a(n) *

- ○ Individual
- ◉ Group/Team/Coalition
- ○ Organization

If group, team, coalition, or organization, please include name

ICPS Smart Pump Safety Workgroup, PCA Safety Summit

Contact Name *

Jim Fuller

Job Title *

President

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NOMINATION REASONING

Please write a brief narrative below that describes why this nominee deserves to be recognized. Please incorporate the answers to the following questions in your narrative based on the award you indicated above.

Write response here *

Organizations have operationalized the safe use of PCA [smart infusion pumps, order sets, staff assessment, electronic medical record (EMR) prompts, documentation, and policies]. However, evidence-based literature recommendations on optimizing each step of the medication use process were not consistently in place. Smart infusion pumps, containing dose error reduction systems (DERS), are an important safety tool for end users involved in administering PCA medications. Smart pumps alert staff to potentially incorrect medications orders, calculation errors, or programming mistakes that could result in incorrect delivery of medications used for PCA. Electronic medical records also contain a variety of tools to enhance safety surrounding the PCA medication use process.

The Indianapolis Coalition for Patient Safety, Inc. (ICPS) provides a forum for Indianapolis-area hospitals to share best practices and work together to solve patient safety issues. A free-standing nonprofit organization (501c3), it is comprised of representatives from the 6 major health systems located in Indianapolis: Community Health Network, Eskenazi Health, Franciscan Health, Indiana University Health, Richard L. Roudebush Veterans Affairs Medical Center, and St. Vincent. Although competitors in the market place, hospital leaders came together and agreed to not compete on safety. Within ICPS, all six health-systems use smart infusion pumps to deliver PCA medications.

Over a 12-month period, ICPS brought together an interdisciplinary, diverse group of content experts (pharmacists, nurses, and respiratory therapists) representing the six local health-systems to review current state processes surrounding PCA. Patient safety organizations' recommendations and each health-system's procedures were reviewed to identify best practices, gaps, and process variation. The group determined significant variation exists surrounding important processes related to PCA: ordering, patient assessment, administration, EMR design, documentation tools, smart pump drug library settings, policies, adverse event monitoring, and education.

Collectively, the group found an opportunity to standardize efforts and developed a series of consensus statements to address these important areas. Health-systems are now in the process of evaluating their current state processes to identify gaps in practice from these recommendations.

PATIENT SAFETY INNOVATION AWARD

Please complete all questions below.

What patient safety initiative has this individual/group/organization created or led? *

Collectively, the group found an opportunity to standardize efforts and developed the "Indianapolis Coalition for Patient Safety, Inc. (ICPS) Patient-Controlled Analgesia (PCA) Safety Summit Consensus Recommendations." This is a series of consensus statements developed to address important processes related to PCA: ordering, patient assessment, administration, EMR design, documentation tools, smart pump drug library settings, policies, adverse event monitoring, and education.

What need did this initiative fill, or what problem did it solve? *

Organizations have operationalized the safe use of PCA. However, evidence-based literature recommendations on optimizing each step of the medication use process were not consistently in place. Electronic medical records also contain a variety of tools to enhance safety surrounding the PCA medication use process. The group determined significant variation exists surrounding important processes related to PCA: ordering (screening, opioid naïve vs. tolerant), patient assessment (documentation, frequency), administration (carrier fluids), EMR design, documentation tools, smart pumps (drug library settings, documentation), dual signatures (requirements, documentation, waste), policies (reporting adverse events, end-tidal CO2, policy elements), monitoring, and education (staff, patient, family). The ICPS PCA Safety Summit Consensus Recommendations address each of these areas of concern and provide directions for health-systems to enhance the safe use of PCA.

What made this initiative innovative or unique from existing efforts? *

To our knowledge, a comprehensive set of recommendations addressing all steps in the medication use process, smart pumps, education, and policies concerning PCA does not exist in the literature. Also, we were able to leverage the expertise of 6 health-systems representing a variety of types of hospitals and clinical expertise to achieve standardization.

What results did this initiative produce? *

21 participants (nurses, pharmacists, respiratory therapists) from 8 hospitals representing the 6 health-systems in Indianapolis completed a PCA Use Process Questionnaire. This contained 150 unique line items/process steps to address. Over the course of 4 in-person meetings between 12/2017 and 6/2018, representing 12.5 hrs of on-site work, the participants were able to come to consensus on 53 specific recommendations. This document is known as the "Indianapolis Coalition for Patient Safety, Inc. (ICPS) Patient-Controlled Analgesia (PCA) Safety Summit Consensus Recommendations."

Has this innovative initiative been recognized by other individuals or groups, or has it been replicated by others since its implementation? *

Not to our knowledge.

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